Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
South Texas Radiology

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-14-1190-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
December 31, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our CPT Code 73721 was not paid according to Workers Comp Fee Schedule. We mailed 2 Requests for Reconsideration & these were also denied. We are requesting that TDI review & find that our reimbursement for CPT code 73721 was incorrect."

Amount in Dispute: $185.81

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In review of the dispute packet submitted by the requestor South Texas Radiology Imaging Center, the Office will maintain that the original payment amount of $870.17 for CPT codes 73718 and 73721 is correct with no additional reimbursement warranted, as the payment was calculated utilizing the multiple reductions for diagnostics per MLN matters 7442 and 7330(Exhibit A)."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 5, 2013	73721	$185.81	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - B13 – Previously paid

Issues

1. Did the requestor support why additional reimbursement is due?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203(b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;…" CMS MLN Matters MM7747 states in pertinent part, "The MPPR (Multiple Procedure Payment Reduction) on diagnostic imaging applies when multiple services are furnished by the same physician to the same patient, in the same session, on the same day… Full payment is made for each PC and TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 75 percent for subsequent PC services furnished by the same physician, to the same patient, in the same session, on the same day. Payment is made at 50 percent for subsequent TC services furnished by the same physician, to the same patient, in the same session on the same day." Review of the submitted documentation finds the following;
    a. CPT code 73718 has the highest payment under the Medicare Physician Fee Schedule.
    b. CPT code 73721 is subject to payment at 75% for subsequent PC services and 50% payment for TC services furnished by the same physician, to the same patient, in the same session, on the same day. Or

Submitted Code	Submitted charge	Medicare Allowable PC	Medicare Allowable TC	MAR (TDI=DWC Conversion Factor / Medicare Conversion Factor) x Non-Facility Price
73721	$1,546.00	$64.51		(55.3 / 34.023) x 64.51 = $104.85 x 75% = $78.64
737321	$1,546.00		$196.38	(55.3 / 34.023) x 196.38 = $319.19 x 50% = $159.59
			Total	$78.64 + $159.60 = 238.23

2. The total allowable reimbursement for the services in dispute is $238.23. This amount less the amount previously paid by the insurance carrier of $238.23 leaves an amount due to the requestor of $0. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Signature	Medical Fee Dispute Resolution Officer	September 24, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.